MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

COPD

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ BREYNA	☐ 80MCG/4.5MCG ☐ 160MCG/4.5MCG	☐ INHALE 2 PUFFS TWICE DAILY	1 DEVICE	
☐ ELIPTA (anoro)	☐ 62.5MCG/25MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	
☐ ELLIPTA (breo)	☐ 50MCG/25MCG ☐ 100MCG/25MCG ☐ 200MCG/25MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	
☐ ELIPTA (incruse)	☐ 62.5MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	
☐ ELIPTA (trelegy)	☐ 100MCG/62.5MCG ☐ 200MCG/62.5MCG	☐ INHALE 1 PUFF ONCE DAILY	1 DEVICE	
☐ DUPIXENT	☐ 200MG/1.4ML PFS ☐ 200MG/1.4ML AUTOINJECTOR ☐ 300MG/1.4ML PFS ☐ 300MG/1.4ML AUTOINJECTOR	☐ INJECT_____MG SQ EVERY_____DAYS		
☐ OHTUVAYRE	☐ 3MG/2.5ML INHALATION SOLUTION	☐ INHALE 3MG TWICE DAILY USING NEBULIZER		
☐ PERFOROMIST	☐ 20MCG/2ML INHALATION SOLUTION	☐ INHALE 20MCG TWICE DAILY USING NEBULIZER		
☐ YUPELRI	☐ 175MC/3ML INHALATION SOLUTION	☐ INHALE 175MCG ONCE DAILY USING NEBULIZER		

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

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Please fax completed form to 1 (855) 595-2955